STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225752	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure three Residents (#8, #2, #10), out of a total sample of 13 residents, were treated with respect and dignity. Specifically, the facility failed to ensure: 1. Resident #8's Foley catheter (tube inserted into the bladder to drain urine) drainage bag was covered with a privacy shield and/or positioned away from the doorway; 2. Resident #2's catheter drainage bag was consistently placed in a privacy bag; and 3. Resident #10 was provided a dignified dining experience. Findings include: Review of the facility's policy titled Dignity, revised 9/2020, indicated but was not limited to: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. - Residents shall be treated with dignity and respect at all times. - Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. - Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by a.) helping the resident to keep urinary catheter bags covered. 1. Resident #8 was admitted to the facility in February 2025 with diagnoses including benign prostatic hyperplasia (BPH), Parkinson's Disease, and Alzheimer's dementia. Review of Resident #8's Minimum Data Set (MDS) assessment, dated 2/18/25, indicated he/she was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review of the MDS assessment indicated Resident #8 had an indwelling catheter. Review of Resident #8's Physician's Orders indicated but were not limited to: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/12/25: Foley catheter care every shift. - 2/15/25: Change Foley catheter bag every night shift every Saturday. On 4/25/25 at 8:42 A.M., the surveyor observed Resident #8 in bed eating breakfast. Resident #8's Foley catheter drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 4/25/25 at 11:55 A.M., the surveyor observed Resident #8 in bed. Resident #8's Foley catheter drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 4/28/25 at 10:21 A.M., the surveyor observed Resident #8 in bed. Resident #8's Foley catheter drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 4/28/25 at 3:51 P.M., the surveyor observed Resident #8 in bed. Resident #8's Foley catheter drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. On 4/29/25 at 7:05 A.M., the surveyor observed Resident #8 in bed. Resident #8's Foley catheter drainage bag was visible from the doorway, filled with clear/yellow urine and was not covered by a privacy bag. Review of Resident #8's indwelling catheter care plan indicated the following: - Focus: The Resident has indwelling catheter related to BPH (revised 3/13/25). - Goal: Resident will be/remain free from catheter-related trauma through review date (target 6/12/25). - Intervention: Resident has a Foley catheter, position catheter bag and tubing below level of the bladder and away from entrance room door (sic) (revised 3/13/25). During an interview on 4/28/25 at 4:18 P.M., Certified Nursing Assistant (CNA) #5 said staff provide daily care to any resident's Foley catheter. CNA #5 said Foley catheter drainage bags should always have a privacy cover and be positioned away from the doorway, so they are not visible. During an interview on 4/29/25 at 9:16 A.M., the Director of Nursing (DON) said Foley catheter bags are cared for daily and changed weekly by staff. The DON said Foley catheter bags should always have a privacy cover and be positioned so they are not visible in the doorway to respect the resident's dignity. 2. Resident #2 was admitted to the facility in August 2019 with diagnoses including reflex neuropathic bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems) and acute kidney failure. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS assessment, dated 2/21/25, indicated Resident #9 had a moderate cognitive deficit as evidenced by a BIMS score of 9 out of 15. Further review of the MDS indicated Resident #2 had an indwelling Foley catheter. On the following days and times, the surveyor observed Resident #2 in bed with his/her catheter drainage bag visible from the hallway labeled with his/her last name, date changed, and amount of urine it contained: - 4/28/25 at 8:08 A.M. and 9:56 A.M. - 4/29/25 at 7:20 A.M. and 9:15 A.M. During an interview on 4/29/25 at 9:17 A.M., CNA #6 said Resident #2's catheter drainage bag was visible from the hallway and contained Resident #2's last name and date changed. CNA #6 said Resident #2's catheter drainage bags should have been stored in a privacy/dignity bag but it was not. During an interview on 4/29/25 at 9:18 A.M., Nurse #5 said if a resident had a catheter drainage bag, then it must always be stored in a privacy/dignity bag to promote the resident's dignity. During an interview on 4/29/25 at 11:16 A.M., Nurse #1 said catheter drainage bags should always be stored in a privacy bag and out of direct view of anyone walking by. During an interview on 4/29/25 at 2:55 P.M., the DON said catheter drainage bags should always be stored in a privacy bag and out of direct view of anyone walking by to promote dignity of the resident. 3. Resident #10 was admitted to the facility in February 2022 with diagnoses including dementia. Review of the MDS assessment, dated 4/15/25, indicated Resident #10 had a moderate cognitive deficit as evidenced by staff interview. During an interview on 4/28/25 at 8:58 A.M., the surveyor observed Resident #10 lying in bed attempting to eat breakfast. Resident #10 said he/she needed help with breakfast and could not eat on their own. On 4/28/25 at 8:59 A.M., the surveyor reported to the DON that Resident #10 had asked for assistance with his/her breakfast. During a follow-up interview on 4/28/25 at 9:51 A.M., the surveyor observed Resident #10 lying in bed attempting to eat breakfast. Resident #10 said no one came in to help him/her eat their breakfast and he/she was still waiting. Resident #10 said he/she was hungry. During an interview on 4/28/25 at 9:52 A.M., the surveyor reported to Nurse #4 that Resident #10 had asked for assistance with his/her breakfast. Nurse #4 said Resident #10 used to be able to eat on their own but after a recent hospitalization he/she required assistance with eating. Nurse #4 said Resident #10 required someone to sit with him/her and feed them. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 9:53 A.M., the surveyor observed a CNA enter Resident #15's room and begin to assist him/her with their breakfast, approximately 54 minutes after he/she first requested assistance. During an interview on 4/29/25 at 7:08 A.M., CNA #1 said Resident #10 had recently declined and required assistance with his/her meals. CNA #1 said Resident #10 was unable to eat on their own without someone feeding them. During an interview on 4/29/25 at 3:18 P.M., the DON said Resident #10 had a decline after his/her recent hospitalization. The DON said Resident #10 now required assistance with meals. The DON said all residents should have a dignified eating experience, including warm food.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a resident group meeting, interviews, and record reviews, the facility failed to ensure concerns from the Resident Council were thoroughly documented to ensure the residents felt their concerns were acted upon timely and included the facility response to the group. Findings include: Review of the facility's policy titled Resident Council, dated 1/2025, indicated but was not limited to the following: - [Facility name] supports a resident council. - Resident council meets on a monthly basis. Those residents who cannot or do not want to attend a council meeting may submit their concerns to a council member for discussion at the meeting. - The Activities Director is there to take the meeting minutes. Review of the facility's policy titled Grievance, revised 12/2021, indicated but was not limited to: - It is the policy of [Facility name] to provide a communication system whereby residents and/or their significant others or representative, can voice concerns about the quality of care received at the facility. - Residents have the right to voice complaints and make suggestions for change without the fear of reprisal, discrimination, coercion or unreasonable interruption of care, treatment and services. - All grievances are to be submitted to the Administrator, whose office is located in the Business Office. - Upon notification of a resident grievance, information sufficient to identify the individual registering the concern, the name of the resident (if not the individual submitting the information), date of receipt, nature of the concern, resident's attending physician and location of the resident will be recorded. - All grievances receive immediate priority and must be investigated with efforts made toward resolution in 72 hours. Review of the Resident Council meeting notes with response indicated but were not limited to the following: January Meeting: 1/28/25 - Nine residents in attendance - Laundry Concerns: two residents reported missing clothing items. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Physician (MD)/Nurse Practitioner (NP) Concerns: one resident expressed concerns about the MD's response to her medical concerns; one resident expressed not seeing the MD in a long time. January Response: - Laundry Response: Continuing to work with laundry to resolve the issue. - MD/NP Response: no response given about MD/NP concerns. February Meeting: 2/25/25 - Eight residents in attendance - Nursing Concerns: three residents expressed concerns regarding long call wait times for care from Certified Nursing Assistants (CNA); one resident expressed further concerns related to CNAs only answering call lights if they were assigned to the resident. February Response: - Nursing Response: The Director of Nursing (DON) went to speak with one resident regarding call light wait times, but the resident could not remember when the incident occurred. The DON's written response also included that she would speak during her staff meetings about answering call lights. The DON's written response included that nursing departments try very hard to answer call lights quickly and that support staff, including nurses, also answer call lights too and if staff are busy with other residents, it may take longer to respond. The DON's written response indicated she had spoken with staff about answering call lights regardless of being assigned to a specific resident. March Meeting: 3/31/25 - Six residents in attendance - Laundry Concerns: two residents reported missing clothing - Housekeeping Concerns: two residents said items were missing or moved from their room without consent. - Miscellaneous Concerns: three residents expressed concerns regarding the smell of cigarette smoke in their rooms during the evening. - MD/NP Concerns: two residents reported concerns regarding lack of follow up to their concerns about medical care by the MD. March Response: - Laundry Response: When clothes get damaged or too heavily stained, they are disposed of and the resident's health care proxy (HCP) are made aware; however, occasionally due to dementia sometimes it is forgotten. - Housekeeping Response: Residents are always made aware when items are going to be stored and they are moved with consent; however, due to dementia sometimes it is forgotten. When they would like the items bought (sic) back to their room, they are always bought (sic) back. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Miscellaneous Concerns: no response given regarding concerns about the smell of cigarette smoke in rooms in the evenings. - MD/NP Response: no response given regarding resident concerns about MD/NP. On 4/28/25 at 11:00 A.M., the surveyor held a group meeting with four residents in attendance. The residents shared the following information: - Two of four residents said they do not believe their concerns are thoroughly addressed when issues are brought forward. - Two of four residents said they have not had any outcome or follow up regarding reports of missing items or items moved from their room. The residents said they have not had discussions with staff about items being replaced or reimbursed. - Two of four residents said they have not had follow up regarding their concerns about meeting with their facility physician. - Three of four residents said they frequently bring up concerns related to call lights and - Two of four residents said they believe Resident Council is not as effective as it should be because they have to consistently bring up the same concerns over and over. During an interview on 4/29/25 at 10:00 A.M., the Activities Director said Resident Council meetings are held on a monthly basis. The Activities Director said she encourages all residents to attend the meetings throughout the month including the day of the meeting during morning rounds. The Activities Director said the residents run the Resident Council meeting and she takes notes regarding the comments, questions or concerns. The Activities Director said the previous month's concerns are reviewed with the Resident Council at the start of each meeting unless they were already addressed individually with a particular resident. The Activities Director said after the meeting is completed, she types up the concerns and sends them to the department heads in the facility. The Activities Director said responses to the concerns are then sent back to her from the specific department heads and reviewed at the next Resident Council meeting. The Activities Director said depending on the concern, a resident may also have an individual follow up. During an interview on 4/29/25 at 10:15 A.M., the Administrator said all Resident Council concerns are reviewed by department heads and a response is given to the Activities Director to review at the next meeting. The Administrator said he reviews all grievances reported from the Resident Council meetings. The Administrator and the surveyor reviewed the concerns brought forward from the previous Resident Council meetings and the group response during the Resident Council meeting held during the survey process. The Administrator said he did not know why there was not a response regarding the residents' concerns about the MD/NP. The Administrator said a lot of the concerns are handled verbally and he did not have any evidence of the resolutions for missing clothing items or other items removed from resident rooms. The Administrator said the facility typically replaces or reimburses for missing items, but did not have evidence of what items were replaced or reimbursed. The Administrator said call light concerns were an on-going issue but did not provide any further evidence related to the responses given to the Resident Council. The Administrator said the facility needed to be clearer and more specific in their responses to resident concerns.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and observations, the facility failed to ensure grievance forms were available in resident care and public areas, so residents and/or visitors were able to access forms without requesting staff assistance. Findings include: Review of the facility's policy titled Grievance, revised 12/2021, indicated but was not limited to: - It is the policy of [Facility Name] to provide a communication system whereby residents and/or their significant others or representative, can voice concerns about the quality of care received at the facility. - Residents have the right to voice complaints and make suggestions for change without the fear of reprisal, discrimination, coercion or unreasonable interruption of care, treatment and services. - All grievances are to be submitted to the Administrator, whose office is located in the Business Office. - Upon notification of a resident grievance, information sufficient to identify the individual registering the concern, the name of the resident (if not the individual submitting the information), date of receipt, nature of the concern, resident's attending physician and location of the resident will be recorded. - All grievances receive immediate priority and must be investigated with efforts made toward resolution in 72 hours. On 4/25/25 at 9:00 A.M., the surveyor toured the facility including all resident care areas and was unable to locate grievance forms. On 4/28/25 at 11:00 A.M., the surveyor held a resident group meeting with four residents in attendance representing one of one unit. One resident slept throughout the meeting. Three of three residents said they were unaware it was possible to file a grievance anonymously. Furthermore, three of three residents said they were unaware of the location of grievance forms in the facility. Two of three residents said they report any concerns directly to a staff member or bring concerns to a Resident Council meeting. During an interview on 4/29/25 at 10:00 A.M., the Activities Director said concerns or grievances are brought up during the monthly Resident Council meeting and brought to the appropriate department heads or Administrator for response. The Activities Director said she encourages residents during morning rounds each day to bring up any concerns or grievances they may have so she can ensure they are addressed. The Activities Director said there used to be a box and forms for grievances in the front lobby by the resident telephone, but she was not sure if it was there anymore. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/25 at 10:15 A.M., the Administrator said grievance forms are available on the unit by the resident telephone in the front lobby as well as by the nurses' station. The Administrator and the surveyor reviewed the observations made as well as the response from the Resident Council meeting. The Administrator said he was unaware forms were not available throughout the facility. The Administrator said residents should have the ability to file a grievance anonymously.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 5. Resident #12 was admitted to the facility in October 2021 with diagnoses including epilepsy (a brain disorder characterized by recurrent seizures, which are caused by abnormal electrical activity in the brain). Review of the MDS assessment, dated 11/3/24, indicated Resident #12 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had a diagnosis of epilepsy. Review of Resident #12's comprehensive care plans failed to indicate a care plan had been developed and implemented for the Resident's diagnosis of epilepsy. During an interview on 4/29/25 at 1:29 P.M., the Director of Nursing said a care plan should have been developed for Resident #12's diagnosis of epilepsy but was not. 6. Resident #37 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, dementia with mild with agitation, major depression disorder (single episode, mild), and anxiety. Review of the comprehensive MDS assessment, dated 10/14/24, indicated Resident #37 had moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15, had Alzheimer's disease, dementia, anxiety, depression and received antipsychotic medication on a routine basis. Review of Resident #37's medical record indicated Physician's Orders for the following antipsychotic medication: -Seroquel 25 mg one time a day for Alzheimer's disease (initiated 10/8/24, discontinued 3/31/25) -Seroquel 12.5 mg one time a day for Alzheimer's disease (initiated 4/1/25, discontinued 4/21/25) -Seroquel 6.25 mg one time a day for Alzheimer's disease (initiated 4/21/25) Review of October 2024 through April 2025 Medication Administration Records indicated Seroquel was administered as ordered by the physician. Review of comprehensive care plans indicated, but was not limited to: -Focus: The resident uses psychotropic medications Quetipaine (Seroquel) related to disease process Alzheimer's disease (10/07/2024) -Intervention: Administer psychotropic medications as ordered by physician; monitor for side effects and effectiveness every shift; consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly; discuss with MD, family regarding ongoing need for use of medication; review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy; Psychiatric consult as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date (target date: 5/22/25) The care plan failed to identify Resident-specific targeted behaviors, signs/symptoms, resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 4/28/25 at 1:35 P.M., the Social Worker said nursing is responsible for developing care plans for psychotropic medications. During an interview on 4/29/25 at 1:29 P.M., the Director of Nursing said a care plan should have been developed for Resident #37's use of Seroquel that identifies the Resident's targeted behaviors and appropriate interventions, including non-pharmacological interventions and measurable goals but was not. 3. Resident #8 was admitted to the facility in February 2025 with diagnoses including Parkinson's Disease, heart failure, and hypertension. Review of Resident #8's MDS assessment, dated 2/18/25, indicated he/she was cognitively intact as evidenced by a BIMS score of 15 out of 15. Furthermore, the MDS assessment indicated Resident #8 received anticoagulant (prevents blood from clotting) medication. Review of Resident #8's Physician's Orders indicated by were not limited to the following: - 2/19/25: Eliquis Oral Tablet 5 mg give 5 mg by mouth two times a day for anticoagulation therapy. - 2/12/25: Anticoagulant Medication - monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vision, shortness of breath, nose bleeds; every shift. Review of Resident #8's comprehensive care plans failed to include an individualized care plan related to anticoagulant usage. During an interview on 4/29/25 at 9:14 A.M., the Director of Nursing (DON) said care plans are initiated by the admitting nurse and each department develops any care plan related to their specific services. The DON said resident's receiving anticoagulant medication should have an individualized care plan related to its use. The DON said Resident #8 should have a care plan for his/her anticoagulant use. 4. Resident #29 was admitted to the facility in March 2025 with diagnoses including Parkinson's Disease, dementia, and history of falling. Review of Resident #29's MDS assessment, dated 3/18/25, indicated he/she had moderately impaired short term and long term memory. Furthermore, the MDS assessment indicated he/she required moderate assistance with activities of daily living (including toileting and personal hygiene) and was always incontinent of urine. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/28/25 at 10:33 A.M., the surveyor observed Resident #29 seated in a wheelchair in his/her room. A urinal was noted to be on the bedside dresser filled with dark amber colored urine and was visible from the hallway. On 4/28/25 at 1:01 P.M., the surveyor observed Resident #29 seated in a wheelchair in his/her room. A urinal was noted to be on the bedside dresser filled with dark amber colored urine and was visible from the hallway. Review of Resident #29's comprehensive care plans failed to include an individualized care plan related to bladder patterns and preferences. During an interview on 4/29/25 at 12:44 P.M., the Director of Nursing (DON) said Resident #29 prefers to put his urinal on his/her bedside dresser after use. The DON said Resident #29 has been educated by staff on calling for assistance after utilizing the urinal so they can discard or clean it. The DON said preferences regarding the Resident's bladder patterns should be documented in the care plan, but she has not gotten around to updating it yet. Based on observations, interviews, and records reviewed, for six Residents (#10, #15, #8, #29, #12, and #37), of 13 sampled residents, the facility failed to ensure that individualized, comprehensive care plans were developed, consistently implemented, and revised as needed. Specifically, the facility failed: 1. For Resident #10, a. to develop and implement a care plan intervention after he/she sustained a fall, and b. to implement the Resident's falls care plan for a floor mat while in bed at all times; 2. For Resident #15, a. to identify non-pharmacological interventions for the use of an antipsychotic medication; and, b. to develop a comprehensive care plan related to hospice services; 3. For Resident #8, to develop a comprehensive care plan related to anticoagulation use; 4. For Resident #29, to develop a comprehensive care plan related to bladder preferences; 5. For Resident #12, to develop a comprehensive care plan to address the Resident's diagnosis of epilepsy (a brain disorder characterized by recurrent seizures, which are caused by abnormal electrical activity in the brain), and 6. For Resident #37, to develop a comprehensive care plan for the use of antipsychotic medication with identified target behaviors, non-pharmacological interventions and measurable goals of treatment. Findings include: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Comprehensive Careplan [sic], last revised 1/1/2020, indicated but was not limited to: -Policy Statement- a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological, and financial needs is developed and implemented for each resident. -Policy Interpretation and implementation - The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive, person-centered care plan will: - Include measurable objectives and timeframes; - Include the resident's stated goals upon admission and desired outcomes; - Incorporate identified problem areas; - Incorporate risk factors associated with identified problems; - Reflect treatment goals, timetables, and objectives in measurable outcomes; - Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. - The comprehensive, person-centered care plan is developed within 14 days after admission. - Assessments of the residents are on going care plans are revised as information about the residents and the residents' conditions changes. - The Interdisciplinary Team must review and update the care plan: - At least quarterly, in conjunction with required quarterly MDS assessment. 1. Resident #10 was admitted to the facility in February 2022 with diagnoses including dementia. Review of the Minimum Data Set (MDS) assessment, dated 4/15/25, indicated Resident #10 had a moderate cognitive deficit as evidenced by staff interview. Review of Resident #10's care plans indicated but was not limited to: - Focus: Resident is a risk for falls status post unwitnessed fall 3/17/25, 1/23/25, and 6/26/24 (Revised 3/19/25) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Goal: Resident will remain free of major injury status post falls (Revised 2/7/25, Target date 4/23/25) - Interventions: - Floor mat while in bed at all times (Initiated 3/19/25) - Refuses alarms (Revised 3/19/25) - Resident will use his/her call light to ask for assistance with ADLs/ambulation (Initiated 4/23/24) - Focus: The resident is at risk for falls (revised 12/2/23) - Goal: The resident will have no major injuries due to falls through next review (Revised 2/7/25, Target date 5/29/25) - Interventions: - Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed (Initiated 8/2/22) - Follow fall protocol (Initiated 8/2/22) - The resident needs a safe environment (Initiated 8/2/22) - The resident uses chair electronic alarm (Initiated 7/5/23) a. Review of Resident #10's medical record indicated he/she sustained an unwitnessed fall. Review of Resident #10's Post Fall Investigation, dated 3/29/25, indicated he/she was found sitting on the floor in front of their chair. Further review Resident #10's Post Fall Investigation, dated 3/29/25, indicated but was not limited to: - New interventions/preventative measures added to care plan: was left blank. Further review of Resident #10's fall risk care plans failed to indicate new interventions were added to prevent future falls following the unwitnessed fall on 3/29/25. During an interview on 4/29/25 at 3:18 P.M., the Director of Nursing (DON) reviewed Resident #10's Post Fall Investigation, dated 3/29/25, and medical record. The DON said she did not see an intervention implemented after Resident #10's fall. The DON said after a resident had a fall the nursing staff should develop and implement an intervention to help prevent further falls or decrease potential injury. The DON said Resident #10 should have had an intervention put in place after his/her fall but did not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 4/28/25 at 2:06 P.M., the surveyor observed the following: - Resident #10 in bed, awake, and conversing with the surveyor. - The floor mat on Resident #10's right side was folded up and leaning against his/her dresser. - The floor mat on Resident #10's left side was folded up and leaning against the wall with a box of gloves resting on top of the floor mat. On 4/28/25 at 3:52 P.M., the surveyor observed the following: - Resident #10 in bed and awake. - The floor mat on Resident #10's right side was folded up and leaning against his/her dresser. - The floor mat on Resident #10's left side was folded up and leaning against the wall with a box of gloves resting on top of the floor mat. On 4/28/25 at 4:15 P.M., the surveyor observed the following: - Resident #10 in bed and awake. - The floor mat on Resident #10's right side was folded up and leaning against his/her dresser. - The floor mat on Resident #10's left side was folded up and leaning against the wall with a box of gloves resting on top of the floor mat. On 4/29/25 at 7:05 A.M., the surveyor observed the following: - Resident #10 in bed and awake. - The floor mat on Resident #10's right side was folded up and leaning against his/her dresser. - The floor mat on Resident #10's left side was folded up and leaning against the wall with a box of gloves resting on top of the floor mat. During an interview on 4/29/25 at 7:08 A.M., Certified Nursing Assistant (CNA) #1 said Resident #10 was a fall risk and should have a floor mat on the floor next to either side of his/her bed. CNA #1 and the surveyor observed Resident #10 in bed. CNA #1 said Resident #10 did not have the floor mats on either side of his/her bed but should. CNA #1 then left Resident #10's room and failed to place the floor mats on either side of his/her bed. During an interview on 4/29/25 at 7:20 A.M., Nurse #4 said Resident #10 was a fall risk and when in bed he/she should have a floor mat on either side of his/her bed. Nurse #4 and the surveyor observed Resident #10 in bed and awake. Nurse #4 said Resident #10's floor mats should have been on either side of his/her bed when he/she was in bed, but the floor mats were folded up and not next to their bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #15 was admitted to the facility in October 2024 with diagnoses including Alzheimer's disease, depression, and anxiety. Review of the MDS assessment, dated 2/24/25, indicated Resident #15 had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of Resident #15's MDS indicated he/she received an antipsychotic medication on a routine basis and was receiving hospice services. Review of Resident #15's current Physician's Orders indicated but was not limited to: - Seroquel 25 milligrams (mg) give 25 mg daily in the morning for behaviors, dated 10/29/24 - Seroquel 50 mg daily in the evening for behaviors, dated 10/29/24 - May be evaluated and admit to Hospice 2/18/2025 a. Review of Resident #15's, March 2025 and April 2025, Medication Administration Record (MAR) indicated Seroquel was administered as ordered by the Physician's orders. Review of Resident #15's comprehensive care plans indicated but was not limited to: - Focus: The resident uses psychotropic medications related to Alzheimer's Dementia with behaviors, depression, anxiety, (Initiated: 10/30/2024) - Goal: The resident will receive least restrictive dose of medication to lessen the following: (specify) (Revised: 02/24/2025, Target Date: 05/16/2025) - Interventions: - Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness every shift. (Initiated: 10/30/2024) - Monitor/document/report as needed any adverse reactions of PSYCHOTROPIC medications. (Initiated: 10/30/2024) - Monitor/record occurrence of for target behavior symptoms (SPECIFY: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. (Initiated: 10/30/2024) - Psych consult as needed. (Initiated: 10/30/2024) - Focus: The resident has a psychosocial well-being problem related to Alzheimer's Dementia with behaviors, depression, anxiety, (Initiated: 10/30/2024) - Goal: Resident will be free of acute symptoms (Revised: 02/24/2025, Target Date: 05/16/2025) - Interventions: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Allow the resident time to answer questions and to verbalize feelings perceptions, and fears. (Initiated: 10/30/2024) - Identify strengths and supports. (Initiated: 10/30/2024) - Medication as ordered: Seroquel. (Initiated: 10/30/2024) - Provide activities of interest. (Initiated: 10/30/2024) Further review of Resident #15's care plans failed to include non-pharmacological interventions for his/her Seroquel use. b. Further reviewed of Resident #15's medical record indicated he/she was admitted to Hospice on 2/19/25. Further review of Resident #15's care plans failed to indicate a hospice care plan had been developed and implemented. During an interview on 4/29/25 at 10:48 A.M., the Social Worker said she was not responsible for developing care plans for psychotropic medications or hospice services. The Social Worker said she was responsible for psychosocial and mood care plans. The Social Worker and the surveyor reviewed Resident #15's care plans. The Social Worker said the interventions on Resident #15's care plans did not include non-pharmacological interventions for the use of his/her Seroquel, but they should have. The Social Worker said Resident #15's did not have a care plan developed and implemented for their hospice services. During an interview on 4/29/25 at 11:17 A.M., Nurse #1 and the surveyor reviewed Resident #15's care plans. Nurse #1 said Resident #15's care plans did not include non-pharmacological interventions for the use of his/her Seroquel, but they should have. Nurse #1 said said Resident #15's did not have a care plan developed and implemented for their hospice services. During an interview on 4/29/25 at 3:18 P.M., the DON said the expectation was for psychotropic care plans to include non-pharmacological interventions. The DON said Resident #15 should have non-pharmacological interventions on his/her psychotropic care plan but he/she did not. The DON said all residents who receive hospice services should have a individualize comprehensive care plan developed for them but Resident #15 did not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review, and interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for four Residents (#12, #22, #37, and #15), out of a total sample of 13 residents . Specifically, the facility failed to review and revise the care plan after comprehensive, significant change, and quarterly assessments were completed to reflect the current status of the Residents. Findings include: Review of the facility's policy titled Comprehensive Care Plan, last revised 1/1/20, indicated but was not limited to: -A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. -The Interdisciplinary Team (IDT) must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment. -The IDT includes: a. The attending physician; b. A registered nurse who has responsibility for the resident; c. A nurse aide who has responsibility for the resident; d. A member of the food and nutrition services staff; e. The resident and the resident's legal representative (to the extent practicable); and f. Other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 1A. Resident #12 was admitted to the facility in October 2021 with diagnoses including epilepsy (a brain disorder characterized by recurrent seizures, which are caused by abnormal electrical activity in the brain). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessments, dated 8/3/24, 11/3/24, and 2/3/25 indicated Resident #12 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had a diagnosis of epilepsy. Review of Resident #12's entire medical record failed to indicate IDT care plan meetings had been conducted after each MDS assessment to review the Resident's total program of care and revise the care plan if needed. B. Resident #22 was admitted to the facility in December 2024 with a stage four pressure ulcer (full-thickness skin loss that extends through the fascia with considerable tissue loss due to prolonged pressure exerted over specific areas of the body). Review of the MDS assessment, dated 3/13/25, indicated Resident #22 was cognitively intact as evidenced by a BIMS score of 15 out of 15 and had a stage four pressure ulcer. Review of Resident #22's entire medical record failed to indicate an IDT care plan meeting had been conducted after the MDS assessment to review the Resident's total program of care and revise the care plan if needed. During an interview on 4/27/25 at 11:20 A.M., Resident #22 said he/she has not participated in any care plan meetings to review his/her plan of care. C. Resident #37 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, dementia with mild agitation, major depression disorder (single episode, mild), and anxiety. Review of the MDS assessments, dated 1/14/25 and 4/16/25, indicated Resident #37 had moderate cognitive impairment as evidenced by a BIMS score of 10 out of 15 and 11 out of 15 respectively, and had an activated healthcare proxy (healthcare agent designated by the resident when competent who has the authority to consent for health care decisions when a resident has been declared, by a physician, not to be competent to make his/her own health care decisions). Review of Resident #37's entire medical record failed to indicate an IDT care plan meeting had been conducted after each MDS assessment to review the Resident's total program of care and revise the care plan if needed. During a telephone interview on 4/28/25 at 10:15 A.M., Resident #37's Health Care Proxy said that she has never heard of or been invited to participate in a care plan meeting to review Resident #37's plan of care. During an interview on 4/28/25 at 1:35 P.M., the Social Worker said she is responsible for coordinating IDT care plan meetings. She said she has not worked consistently and was out for an extended period of time over the past six to eight months and was not coordinating and conducting any care plan meetings as required. During an interview on 4/29/25 at 1:29 P.M., the Director of Nursing (DON) said she is aware care plan meetings have not been happening for quite some time. She said there have been a lot of staffing challenges and required care plan meetings have not been occurring. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #15 was admitted to the facility in October 2024 with diagnoses including Alzheimer's disease. Review of the MDS assessment, dated 2/24/25, indicated Resident #15 had a severe cognitive deficit as evidenced by a BIMS score of 3 out of 15. Further review of Resident #15's MDS indicated but was not limited to the following: - Always incontinent of bowel and bladder; - Walking 10 feet: not attempted - Toileting: Dependent - Bathing: Dependent - Eating: substantial/maximum assistance Review of Resident #15's Activity of Daily Living flow sheets indicated but was not limited to: - Always incontinent of bowel and bladder; - Walking: Dependent - Toileting: Dependent - Bathing: Dependent - Eating: requires assistance Review of Resident #15's comprehensive care plans indicated but was not limited to: - Occasionally incontinent of bowel (initiated 10/30/24) - Occasionally incontinent of bladder (initiated 10/30/24) - Walking: requires assistance by one staff member to walk with a walker (initiated 10/30/24) - Toileting: assist (initiated 10/30/24) - Bathing: assist (initiated 10/30/24) - Eating: independent with set-up (initiated 10/30/24) During an interview on 4/29/25 at 3:18 P.M., the DON said when a resident has a significant change of condition their care plans should be reviewed and revised to accurately reflect each resident's needs then reviewed at the care plan meeting. The DON reviewed Resident #15's care plans and said they were not updated or reviewed to reflect the Resident's significant change in condition. The DON said because of staffing challenges, care plan meetings were not occurring as they should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the facility's policy titled Air Mattress, last revised 7/20/20, indicated but was not limited to: -Nursing staff will ensure the air mattress is in place, properly functioning, and adjusted to the resident's weight and needs. -Staff must ensure the air mattress is not overly inflated or deflated, which can pose a risk of falls or impaired healing. Resident #22 was admitted to the facility in December 2024 with a stage four pressure ulcer (full-thickness skin loss that extends through the fascia with considerable tissue loss due to prolonged pressure exerted over specific areas of the body). Review of the MDS assessment, dated 3/13/25 indicated Resident #22 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had a stage four pressure ulcer and had a pressure reducing device in bed. On 4/25/25 at 8:54 A.M., the surveyor observed Resident #22 lying in bed asleep. An air mattress was on the bed and set to 350 pounds (lbs.). On 4/27/25 at 11:20 A.M., the surveyor observed Resident #22 sitting upright in bed. An air mattress was on the bed and set to 350 lbs. On 4/29/25 at 9:15 A.M., the surveyor observed Resident #22 sitting upright in bed. An air mattress was on the bed and set to 350 lbs. Review of December 2024 through April 2025 Physician's Orders failed to indicate an order for an air mattress. Review of the medical record indicated Resident #22 weighed 180.8 lbs. on 4/1/25. Further review of the medical record failed to indicate any evidence that nursing staff ensured Resident #22's air mattress was in place, properly functioning, adjusted to the resident's weight and was not overly inflated or deflated. During an interview on 4/29/25 at 1:29 P.M., the DON said Resident #22's air mattress should not be set to 350 lbs. She said residents with air mattresses need to have physician's orders for their use that include settings for each resident according to their weight, and staff need to monitor them to ensure the mattresses are set correctly. 3. Resident #34 was admitted to the facility in February 2025 and had diagnoses including Alzheimer's disease and a history of falls. Review of the MDS assessment, dated 2/12/25, indicated Resident #34 had severe cognitive impairment as evidenced by a BIMS score of 99, indicating he/she was unable to complete the assessment, and had a pressure reducing device in bed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/25/25 at 9:02 A.M., the surveyor observed Resident #34 lying in bed awake. An air mattress was on the bed and set to 400 lbs. On 4/28/25 at 8:12 A.M., the surveyor observed Resident #34 lying in bed asleep. An air mattress was on the bed and set to 400 lbs. Review of February 2025 through April 2025 Physician's Orders failed to indicate an order for an air mattress. Review of the medical record indicated Resident #34 weighed 121.9 lbs. on 4/1/25. Further review of the medical record failed to indicate any evidence that nursing staff ensured Resident #34's air mattress was in place, properly functioning, adjusted to the resident's weight and was not overly inflated or deflated. During an interview on 4/29/25 at 1:29 P.M., the DON said Resident #34's air mattress should not be set at 400 lbs. She said residents with air mattresses need to have physician's orders for their use that include settings for each resident according to their weight, and staff need to monitor them to ensure the mattresses are set correctly. Based on observations, interviews, and records reviewed, for three Residents (#10, #22, and #34), of 13 sampled residents, the facility failed to ensure care was provided to residents in accordance with professional standards of practice. Specifically, the facility failed: 1. For Resident #10, to ensure a physician's order was obtained prior to sending him/her to the hospital; 2. For Resident #22, to ensure a physician's order for the use of an air mattress, including settings, was obtained prior to its use; and 3. For Resident #34, to ensure a physician's order for the use of an air mattress, including settings, was obtained prior to its use. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #10 was admitted to the facility in February 2022 with diagnoses including dementia and bullous pemphigoid (chronic, autoimmune skin condition that causes large fluid-filled blisters). Review of the Minimum Data Set (MDS) assessment, dated 4/15/25, indicated Resident #10 had a moderate cognitive deficit as evidenced by staff interview. Review of Resident #10's medical record indicated he/she was transferred to the hospital for a change in his/her condition on the following days: - 3/17/25; - 4/5/25; and, - 4/15/25. Further review of Resident #10's medical record failed to indicate a physician's order was obtained to transfer him/her to the hospital on 3/17/25, 4/5/25, and 4/15/25. During an interview on 4/29/25 at 11:04 A.M., Nurse #1 said when a resident needed to be sent out to the hospital an order for the transfer must be obtained from the physician or physician's extender and transcribed into the resident's medical record. Nurse #1 reviewed Resident #10's medical record and said he could not find any orders to send Resident #10 to the hospital on 3/17/25, 4/5/25, and 4/15/25. Nurse #1 said there should have been orders, but there wasn't. During an interview on 4/29/25 at 3:18 P.M., the Director of Nursing (DON) reviewed Resident #10's medical record and said she did not see an order to transfer Resident #10 to the hospital on 3/17/25, 4/5/25, and 4/15/25 but he/she should have had an order. The DON said all residents must have an order to be transferred to the hospital.

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Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 2. Resident #37 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, dementia with mild with agitation, major depression disorder (single episode, mild), and anxiety. Review of the MDS assessment, dated 10/14/24, indicated Resident #37 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 11 out of 15, had Alzheimer's disease, dementia, anxiety, and depression. Further review of Resident #22's medical record failed to indicate a Social Service assessment or evaluation had been completed on or since admission to the facility. Resident #22's electronic medical record indicated a Social Service assessment was 200 days overdue. During an interview on 4/28/25 at 1:35 P.M., the Social Worker said she has not been working in the facility consistently over the past six to eight months and has not been able to keep up with social service assessments, trauma assessments and care plans. She said she met with Resident #37 and his/her family at the time of admission in October 2024 and took handwritten notes, but did not enter them into the Resident's medical record. The Social Worker said during her initial visit with the Resident she was made aware that Resident #37 had trauma from significant losses of his/her spouse and a child. She said she should have conducted a trauma assessment and developed a care plan with approaches to care that meet his/her needs when she identified the trauma in October 2024 but didn't. Based on record review and interview, the facility failed to ensure a person-centered plan of care with individualized interventions for trauma-informed care was developed for two Residents (#29 and #22), out of a total sample of 13 residents. Specifically, the facility failed to assess and implement care plan interventions for: 1. Resident #29 with a history of a traumatic and violent event; and 2. Resident #22 with a history of traumatic events. Findings include: Review of the facility's policy titled PTSD (Trauma), revised 7/2020, indicated but was not limited to the following: - This policy is designed to ensure that residents with actual or suspected Post-Traumatic Stress Disorder (PTSD) received appropriate screening, diagnosis, care planning and treatment in accordance with CMS regulations and clinical best practices. - PTSD is a recognized mental health condition that may affect residents' quality of life, safety, and functional abilities. - All new residents shall be screened for history of trauma or PTSD as part of the admission assessment by nursing and/or social services. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Veterans and individuals with a known psychiatric history shall receive further evaluation by the interdisciplinary team (IDT). - A personalized care plan shall be developed for each resident diagnosed with PTSD, addressing identified triggers and strategies to minimize them, behavioral symptoms and appropriate interventions, trauma-informed communication methods, medication regimen (if applicable), and counseling or psychotherapy goals. - The care plan shall be reviewed quarterly and as needed based on changes in condition. 1. Resident #29 was admitted to the facility in March 2025 with diagnoses including Parkinson's disease and dementia. Review of Resident #29's Minimum Data Set (MDS) assessment, dated 3/18/25, indicated their short- and long-term memory was moderately impaired. The MDS assessment further indicated Resident #29 experienced periods of verbal behavioral symptoms towards others and rejected care. Review of Resident #29's paper medical record included an article in his/her chart indicating a traumatic and violent life event occurring in his/her youth resulting in physical injuries. Further review of Resident #29's medical record failed to indicate a Social Service assessment or evaluation had been completed on or since admission to the facility. Resident #29's electronic medical record indicated a Social Service assessment was 46 days overdue. Review of Resident #29's comprehensive care plans failed to indicate he/she had a history of a traumatic/violent event. During an interview on 4/28/25 at 2:11 P.M., the Social Worker said she is responsible for completing Social Service assessments on residents when they are admitted to the facility. The Social Worker said she was behind on completing the assessments and was trying to get caught up. The Social Worker said she has met with all the residents since they were admitted but has not input any information into their medical records. The Social Worker said she was not completing trauma assessments for any residents in the facility. She said she was recently educated by the consulting Social Worker on needing to complete trauma assessments but has not implemented the forms at this time. The Social Worker said she had met with Resident #29, and she put the article related to his/her traumatic/violent life event in the paper medical record. The Social Worker said she considered this event a history of trauma. The Social Worker said she should have completed a trauma assessment and updated the care plan to reflect this information but did not.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record review and interview, the facility failed to provide the appropriate treatment and services for one Resident (#29), with a history of a traumatic and violent life event, out of a total sample of 13 residents. Specifically, the facility failed to make a referral to Behavioral Health Services upon admission resulting in a 46-day delay of services. Findings include: Review of the facility's policy titled PTSD (Trauma), revised 7/2020, indicated but was not limited to the following: - This policy is designed to ensure that residents with actual or suspected Post-Traumatic Stress Disorder (PTSD) received appropriate screening, diagnosis, care planning and treatment in accordance with CMS regulations and clinical best practices. - PTSD is a recognized mental health condition that may affect residents' quality of life, safety, and functional abilities. - All new residents shall be screened for history of trauma or PTSD as part of the admission assessment by nursing and/or social services. - Veterans and individuals with a known psychiatric history shall receive further evaluation by the interdisciplinary team (IDT). - A qualified mental health professional (psychiatrist, psychologist, psychiatric NP (Nurse Practitioner), etc.) will evaluate residents with suspected PTSD and document findings in the medical record. - A personalized care plan shall be developed for each resident diagnosed with PTSD, addressing identified triggers and strategies to minimize them, behavioral symptoms and appropriate interventions, trauma-informed communication methods, medication regimen (if applicable), and counseling or psychotherapy goals. - The care plan shall be reviewed quarterly and as needed based on changes in condition. Resident #29 was admitted to the facility in March 2025 with diagnoses including Parkinson's disease and dementia. Review of Resident #29's Minimum Data Set (MDS) assessment, dated 3/18/25, indicated their short- and long-term memory was moderately impaired. The MDS assessment further indicated Resident #29 experienced periods of verbal behavioral symptoms towards others (threatening others, screaming at others, cursing at others) and rejected care. Review of Resident #29's paper medical record included an article in his/her chart indicating a traumatic and violent life event occurring in his/her youth resulting in physical injuries. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #29's Physician's Orders indicated but were not limited to: - 3/11/25: May have psych consult/treatment Review of Resident #29's medical record failed to indicate a referral to a psychiatrist or psychologist were made on or after admission. Further review of Resident #29's medical record failed to indicate a Social Service assessment or evaluation had been completed on or since admission to the facility. Resident #29's electronic medical record indicated a Social Service assessment was 46 days overdue. Review of Resident #29's comprehensive care plans indicated: - Focus: The Resident uses psychotropic medications (Divalproex, Gabapentin, Quetiapine) related to delirium and agitation (initiated 3/11/25); Goal: The resident will receive least restrictive dose of medication to lessen the following: aggressive and compulsive behaviors (target date 6/29/25); Interventions: psych consult as needed (initiated 3/11/25), monitor/document/report PRN (as needed) any adverse reactions to psychotropic medications (initiated 3/12/25), administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness every shift (initiated 3/11/25) - No care plan was developed to include a treatment plan for Behavioral Health Services. - No care plan was developed related to Resident #29's history of a traumatic/violent event. During an interview on 4/28/25 at 2:11 P.M., the Social Worker said Resident #29 had a history of trauma related to an incident which occurred in his/her youth. The Social Worker said the appropriate assessments and care plans were not developed on admission. The Social Worker said she makes the referrals to consulting psychiatric services. The Social Worker said based on Resident #29's history and behaviors a referral to psychiatric services should have been made but was not.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 2. Resident #37 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, dementia with mild with agitation, major depression disorder (single episode, mild) and anxiety. Review of the MDS assessment, dated 10/14/24, indicated Resident #37 had moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15, had Alzheimer's disease, dementia, anxiety, depression and received antipsychotic medication on a routine basis. Review of Resident #37's medical record indicated Physician's Orders for the following antipsychotic medication: -Seroquel 25 mg one time a day for Alzheimer's disease (initiated 10/8/24, discontinued 3/31/25) -Seroquel 12.5 mg one time a day for Alzheimer's disease (initiated 4/1/25, discontinued 4/21/25) -Seroquel 6.25 mg one time a day for Alzheimer's disease (initiated 4/21/25) Review of Resident #37's medical record indicated the following recommendation was made during the consultant pharmacist's monthly MRR, dated 10/29/24: - Physician, nursing and the Director of Nursing: Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. Recommended movement test, such as AIMS or DISCUS, to be performed initially (within 30 days), and then at least every six months while this resident continues on antipsychotic therapy. A handwritten note at the bottom of the recommendation indicated: Done 12/16/24. Review of the consultant psychiatric NP's Progress note, dated 12/16/24, indicated she conducted an AIMS assessment for Resident #37 on 12/16/24, 48 days after the recommendation was made by the pharmacist. During an interview on 4/29/25 at 1:29 P.M., the DON said the pharmacist's recommendations for an AIMS assessment should have been completed timely. Based on document review and interview, the facility failed to ensure monthly medication regimen reviews (MRR) were communicated to the physician and addressed in a timely manner for two Residents (#15 and #37), out of a total sample of 13 residents. Specifically, the facility failed: 1. For Resident #15, to ensure October 2024 consultant pharmacist recommendations for nursing to perform an Abnormal Involuntary Movement Scale (AIMS) assessment (a clinical outcome checklist completed by a healthcare provider to assess the presence and severity of adverse outcomes, such as abnormal movements of the face, limbs, and body) were acted upon timely; and 2. For Resident #37, to ensure October 2024 consultant pharmacist recommendation for nursing to perform an AIMS assessment was acted upon timely. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: Review of the facility's policy titled Drug Regimen Review, effective date 1/1/2001, indicated but was not limited to: - Drug Regimen Review consists of a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. - The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. - Findings and recommendations are reported to the Administrator, Director of Nursing, the physician responsible and the Medical Director, when appropriate. - The Consultant Pharmacist documents potential or actual medication therapy problems and communicates them to the responsible physician or the Director of Nursing. A written note is provided to the physician, and a copy is sent to the facility - The Consultant Pharmacist documents all potential or actual significant nursing documentation problems found relating to medications and communicates them to the Director of Nursing. Review of the facility's policy titled Consultant Pharmacist/Pharmacy Services, undated, indicated but was not limited to: - Reviewing the medication regimen of each resident at least monthly, utilizing federally mandated standards of care in addition to other applicable standards, and documenting the review and findings in the resident's medical record. - Communicating potential or actual problems detected relating to medication therapy orders to the responsible physician. - Reviewing Medication Administration Records (MAR) and physician orders monthly to ensure proper documentation of medication orders and administration of medications to residents. - Submitting a written report of findings and recommendations resulting from the review of the medication regimen and nursing documentation records to the attending physician and Director of Nursing. Review of the National Library of Medicine (NLM), dated 5/15/23, indicated but was not limited to: - The AIMS is administered every three to six months to monitor the patient for the development of TD (tardive dyskinesia, is a syndrome characterized by abnormal involuntary movements of the patient's face, mouth, trunk, or limbs). (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292174/) 1. Resident #15 was admitted to the facility in October 2024 with diagnoses including Alzheimer's disease, depression, and anxiety. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Sets (MDS) assessment, dated 2/24/25, indicated Resident #15 had a severe cognitive deficit as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of Resident #15's MDS indicated he/she received an antipsychotic medication on a routine basis and was receiving hospice services. Review of Resident #15's current Physician's Orders indicated but was not limited to: - Seroquel 25 milligrams (mg) give 25 mg daily in the morning for behaviors, dated 10/29/24 - Seroquel 50 mg daily in the evening for behaviors, dated 10/29/24 Review of the medical record indicated but was not limited to: - 10/29/24 Pharmacy Consultant Note- Pharmacy Consultant MRR Review: Orders reviewed -See report for new recommendation Review of the MRR, dated 10/29/24, indicated but was not limited to: - Routine: Nursing - Antipsychotics have the capacity to cause tardive dyskinesia and other movement disorders. Recommended movement test, such as AIMS or Dyskinesia Identification System: Condensed User Scale (DISCUS), to be performed initially (within 30 days), and then at least every six months while this resident continues on antipsychotic therapy. Further review of the medical record indicated an AIMS assessment for Resident #15 was completed on 12/16/24 by the Psychiatric Nurse Practitioner (NP). During an interview on 4/29/25 at 10:48 A.M., the Social Worker said she was not responsible for completing AIMS assessments on residents; it was usually completed by the Psychiatric NP. The Social Worker said she would usually make a referral for the Psychiatric NP to evaluate any resident receiving antipsychotic medication. The Social Worker said she was behind in making referrals and did not make a referral for Resident #15 to be seen by the Psychiatric NP until 12/2/24. The Social Worker said Resident #15 was seen by the Psychiatric NP on 12/16/24 and an AIMS assessment was completed then. During an interview on 4/29/25 at 11:17 A.M., Nurse #1 said the Psychiatric NP comes in and sees the residents. Nurse #1 said he was not sure if the Psychiatric NP completed the AIMS assessment, but nursing could also complete an AIMS assessment. Nurse #1 said any resident who was admitted on antipsychotic medication should have an AIMS assessment completed on admission to establish a baseline for possible adverse side effects. During an interview on 4/29/25 at 3:01 P.M., the Director of Nursing (DON) said an AIMS assessment could be completed by any nurse or by the Psychiatric NP. The DON said the expectation was for Resident #15 to have an AIMS assessment completed on admission to establish a baseline for possible adverse side effects of antipsychotic use.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on record review and interview, the facility failed to ensure for two Residents (#37 and #15), out of a total sample of 13 residents, that each resident's drug regimen was free from unnecessary psychotropic medications to promote or maintain the Residents' highest practicable mental, physical, and psychosocial well-being. Specifically, the facility failed to ensure: 1. For Resident #37, that targeted behaviors and signs and symptoms of potential adverse consequences were monitored for the use of the antipsychotic medication Seroquel; and 2. For Resident #15, to ensure a rationale for use of Seroquel was documented and a gradual dose reduction (GDR) was attempted, unless documented by the prescriber as clinically contraindicated in the medical record. Findings include: Review of the facility's policy titled Antipsychotic Medication, last revised 9/17/20, indicated but was not limited to: -Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. -The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. -Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will: -Re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks (at the initial MDS assessment) to consider whether or not the medication can be reduced, tapered, or discontinued. -Based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication. -Antipsychotic medication may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. 1. Resident #37 was admitted to the facility in October 2024 and had diagnoses including Alzheimer's disease, dementia with mild with agitation, major depression disorder (single episode, mild) and anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 10/14/24, indicated Resident #37 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 11 out of 15, had Alzheimer's disease, dementia, anxiety, depression and received antipsychotic on a routine basis. Review of Resident #37's medical record indicated Physician's Orders for the following antipsychotic medication: -Seroquel 25 mg one time a day for Alzheimer's disease (initiated 10/8/24, discontinued 3/31/25) -Seroquel 12.5 mg one time a day for Alzheimer's disease (initiated 4/1/25, discontinued 4/21/25) -Seroquel 6.25 mg one time a day for Alzheimer's disease (initiated 4/21/25) The physician's orders failed to identify resident specific target behaviors and failed to indicate to monitor for potential adverse consequences for its use. Review of October 2024 through April 2025 Medication Administration Records (MAR) indicated Seroquel was administered as ordered by the physician. Further review of the medical record failed to identify any resident specific targeted behaviors were identified and monitored to determine the efficacy of Seroquel and that the Resident was monitored for potential adverse consequences for its use. During an interview on 4/19/25 at 1:29 P.M., the surveyor reviewed Resident #37's medical record with the Director of Nursing (DON). She said there were not resident specific targeted behaviors identified for the use of Seroquel and potential side effects were not being monitored but should be. 2. Resident #15 was admitted to the facility in October 2024 with diagnoses including Alzheimer's disease, depression, and anxiety. Review of the MDS assessment, dated 2/24/25, indicated Resident #15 had a severe cognitive deficit as evidenced by a BIMS score of 3 out of 15. Further review of Resident #15's MDS indicated he/she received an antipsychotic medication on a routine basis, and he/she did not have a GDR attempted and there was no physician documentation indicating a GDR was clinically contraindicated. Review of Resident #15's current Physician's Orders indicated but was not limited to: - Seroquel 25 milligrams (mg) give 25 mg daily in the morning for behaviors, dated 10/29/24 - Seroquel 50 mg daily in the evening for behaviors, dated 10/29/24 Review of Resident #15's MAR for April 2025 indicated he/she had received their Seroquel as prescribed. Review of the medical record indicated Resident #15 was followed by a consultant psychotherapy Nurse Practitioner (NP) whose recommendations included but were not limited to: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/16/24 GDR Seroquel 25 mg A.M. and 50 mg P.M. not recommended potential risk for psychiatric destabilization. - 1/13/25 Continue Seroquel 25 mg A.M. and 50 mg P.M Further review of the medical record failed to indicate this information was reviewed and documented on by the physician or NP. Review of Resident #15's Physician's Progress Notes, dated 10/30/24, 11/6/24, 11/13/24, and 2/5/25 failed to indicate a rational for Seroquel use and failed to indicate a documented clinical rationale for why a GDR of Seroquel was contraindicated or not attempted. During an interview on 4/29/25 at 11:23 A.M., the Social Worker said she had nothing to do with resident's use of medications and all she would do was make a referral to the Psychiatric NP. During an interview on 4/29/25 at 3:01 P.M, the DON said the Doctor should have documented the rationale for Resident #15's use of Seroquel and documented why a GDR was recommended or contraindicated but that was not completed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 4/25/25 at 8:49 A.M., the surveyor entered the open door of the clean utility room in the nursing unit hallway. Inside the room were two unlocked cabinets with several items noted inside including: -11 bottles of Antifungal powder with Miconazole Nitrate 2% -28 tubes of moisture barrier antifungal cream mupirocin ointment 2% -9 bottles of DermaCream During an interview on 4/29/25 at 1:29 P.M., the Director of Nursing said the clean utility room has a keypad lock on it and the door should be closed and locked at all times to prevent residents from accessing the hazardous items inside. 4. Resident #22 was admitted to the facility in December 2024 with a stage four pressure ulcer (full-thickness skin loss that extends through the fascia with considerable tissue loss due to prolonged pressure exerted over specific areas of the body). On 4/25/25 at 8:54 A.M., 9:07 A.M., 11:12 A.M. and 12:00 P.M., the surveyor observed a bottle of Daikin solution (a strong antiseptic solution that contains bleach used in wound care), with a prescription label affixed to it with the Resident's name on it, on Resident #22's bureau. During an interview on 4/19/25 at 1:29 P.M., the DON said that all treatments are to be securely stored in the treatment cart and not left out at the Resident's bedside. Based on observation, interview, and document review, the facility failed to ensure all drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure the facility medication room was locked at all times when not in use or in direct view of a licensed nurse to prevent the potential unauthorized access to medications; 2. Make sure licensed staff locked one of one treatment carts, which contained numerous topical treatments and biologicals, when it was not in use and left in the hallway where it could be accessed by residents or passersby; 3. Ensure the clean utility room, which contained topical treatments, was locked when not in direct supervision of a licensed nurse on one of one units; 4. For Resident #22, ensure their prescribed Daikin solution (a strong antiseptic solution that contains bleach used in wound care) was properly stored, and secured to ensure safe administration; and 5. For Resident #10, provide secure, safe storage for their triamcinolone cream (a prescription corticosteroid cream used to treat skin conditions). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Findings include: Review of the facility's policy titled Storage of Medications, dated as revised 9/17/2020, indicated but was not limited to the following: - the facility shall store all drugs and biologicals in a safe, secure, and orderly manner - the nursing staff shall be responsible for maintaining medication storage in a safe manner - only persons authorized to prepare and administer medications shall have access to the medication room, including any keys - compartments (including, but not limited to, drawers, cabinets, rooms, carts, and boxes) containing drugs or biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others 1. During an initial tour of the facility on 4/25/25 at 7:50 A.M., the surveyor observed the facility medication room, which is behind the nurses' station and directly next to the time clock where all staff punch in and out, with a padlock on the door that was not secured in the locked position. On 4/25/25 at 8:25 A.M., the surveyor observed Nurse #1 passing medications. Nurse #1 entered the medication room behind the desk to retrieve a medication from the emergency kit (E-Kit). He was observed to twist the padlock but not use a key to unlock it and open the medication room door. Upon exiting the medication room, he was observed to place the padlock on the door and turn it to line up the shackle to the lock body but not secure the shackle down into the lock body engaging the locking mechanism of the padlock and securing the medication room door. On 4/25/25 at 8:45 A.M., the surveyor observed Nurse #2 passing medications. Nurse #2 entered the medication room to retrieve a medication from the E-Kit. She was observed to twist the padlock but not use a key to unlock it and open the medication room door. Upon exiting the medication room, she was observed to place the padlock on the door and turn it to line up the shackle to the lock body but not secure the shackle down into the lock body engaging the locking mechanism of the padlock and securing the medication room. She said she doesn't know why the medication room isn't kept locked and was unsure if the licensed nurses had a key on the very full key rings they carried. The door remained unlocked following the conversation with the surveyor. At 9:01 A.M., Nurse #2 returned to the medication room to retrieve another medication from the E-Kit. She removed the padlock without using the key to unlock it and upon exiting the room, placed the padlock back on the door, but was not observed to engage the lock, leaving the door unlocked and unsecured. On 4/25/25 the surveyor made the following observations: - 12:43 P.M., the medication room unlocked with the padlock unsecured on the door and no licensed nurses in direct view of the room. The shackle of the lock was lined up to the lock body but not closed to engage the lock. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 1:04 P.M., Nurse #2 was exiting the medication room and said she was leaving to go to lunch. She was observed to place the padlock on the door and line up the shackle to the lock body but not close it to engage the locking mechanism. During an interview on 4/25/25 at 1:06 P.M., Nurse #1 observed the unlocked padlock on the medication room door with the surveyor and said he isn't sure why the medication room doesn't lock but assumes the padlock was placed on the door in an effort to secure the room. He said the padlock was not locked on the door and should be locked at all times when a licensed nurse is not actively in the medication room. He could not explain why the door had remained unlocked and unsecured throughout the day. During an interview on 4/29/25 at 8:36 A.M., the Director of Nurses (DON) said the expectation is that staff lock the medication room when they are not actively using it and that the door should be locked at all times and based on the surveyor's observations on 4/25/25 that had not occurred. 2. Throughout the survey the surveyors made the following observations of the treatment cart, which contained topical creams, sprays and ointments, and was left in the hallway outside of room [ROOM NUMBER]: 4/25/25: the treatment cart was unlocked, unsecured and unattended by a licensed nurse at 7:57 A.M., 8:23 A.M., and 12:45 P.M. 4/28/25: the treatment cart was unlocked and unattended by a licensed nurse at 8:17 A.M., 9:55 A.M., and 12:19 P.M. 4/29/25: the treatment cart was unlocked, unsecured and unattended by a licensed nurse at 7:32 A.M. and 8:04 A.M. During an interview on 4/29/25 at 8:05 A.M., Nurse #1 said the treatment cart is supposed to be locked at all times when not in use or attended by the licensed nurse. It should not be left unlocked in the hallway where anyone has access to it as there were sprays, creams and other biological products in the cart. During an interview on 4/29/25 at 8:36 A.M., the DON said the treatment cart should be locked and the items in it secured at all times when not in direct use by the licensed nurses during a treatment. 5. Resident #10 was admitted to the facility in February 2022 with diagnoses including dementia and bullous pemphigoid (chronic, autoimmune skin condition that causes large fluid-filled blisters). Review of the Minimum Data Set (MDS) assessment, dated 4/15/25, indicated Resident #10 had a moderate cognitive deficit as evidenced by staff interview. On the following days and times, the surveyor observed a container of Triamcinolone Acetonide Cream on Resident #10's dresser: - 4/28/25 at 8:04 A.M., (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 4/28/25 at 8:58 A.M., - 4/28/25 at 9:51 A.M., - 4/28/25 at 2:06 P.M., - 4/28/25 at 3:52 P.M., - 4/28/25 at 4:15 P.M., and - 4/29/25 at 7:08 A.M. During an interview on 4/29/25 at 7:20 A.M., Nurse #4 and the surveyor observed a container of Triamcinolone Acetonide Cream on Resident #10's dresser. Nurse #4 said the Triamcinolone Acetonide Cream should be stored in a secure place out of the reach of residents and not on Resident #10's dresser. During an interview on 4/29/25 at 11:04 A.M., Nurse #1 said the Triamcinolone Acetonide Cream should be stored in secure place out of the reach of residents and not on Resident #10's dresser. Nurse #1 said it was not safe to store the Triamcinolone Acetonide Cream because someone could get into it and eat it. During an interview on 4/29/25 at 3:18 P.M., the DON said all medication and treatments should not be left out and unattended and not left in residents' rooms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to maintain safe and clean equipment, in one of one kitchenette. Findings include: Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised January 2023, indicated but was not limited to the following: 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the Unit Kitchen Procedure provided by the facility indicated but was not limited to: -Expired, undated, and uncovered items should be discarded. Shelves should be clean, neat and tidy. On 4/25/25 at 8:08 A.M., the surveyor observed the following in the facility's one kitchenette: -On top of the microwave was a square glass food storage container with a lid filled with what appeared to be pasta and meat sauce. The food storage container was undated, unlabeled with its contents felt room temperature to touch. -Inside the Refrigerator, the floor of the refrigerator had multiple brown and pink splatters of a sticky substance. The shelves in the door had brown spills and splatters on the wall, shelf floor and in the corners. On 4/25/25 at 12:20 P.M., the surveyor and Food Service Manager (FSM) toured the unit kitchenette. The FSM said dietary staff are responsible for stocking and ensuring the cleanliness of the kitchenette and check it at the beginning and the end of their shifts. She said if it requires deeper cleaning, they will inform the maintenance department and they will take care of it. The FSM said both the refrigerator and the refrigerator/freezer combination units need to be cleaned. She said food in storage containers should not be left on top of the microwave and should be labeled, dated and stored in the refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections while the facility was experiencing a Group A streptococcal (GAS - bacteria that can cause various infections, ranging from mild sore throat to severe invasive diseases) outbreak. Specifically, the facility failed to: 1. Ensure staff utilized appropriate personal protective equipment (PPE) when entering in and out of resident rooms who were on transmission-based precautions for GAS; 2. Maintain an accurate surveillance system that reflected potential illnesses and infections in the facility; and 3. Ensure staff performed proper hand hygiene with glove use during a dressing change for a Resident (#10). Findings include: 1. During an interview on 4/25/25 at 7:27 A.M., the Director of Nursing (DON) said she was also the Infection Preventionist (IP). She said she was contacted by the epidemiology board about a week ago that she had two residents that tested positive for GAS in the hospital, so she tested the whole building which consisted of only one floor/unit. She said a total of six residents tested positive and were currently on contact/droplet isolation precautions for GAS but were asymptomatic. Review of Centers for Disease Control and Prevention (CDC) guidance titled About Group A Strep Infection, dated 3/1/24, indicated but was not limited to the following: Key points: -Group A Streptococcus (group A strep bacteria) can cause many different infections. These infections range from minor to serious. -Group A strep bacteria can also cause inflammatory diseases. -Group A strep bacteria are contagious. -Generally, people spread the bacteria to others through respiratory droplets or direct contact. How it spreads: -Group A strep bacteria are very contagious. Some people infected with group A strep bacteria don't have symptoms or seem sick. They can still spread the bacteria to others. Generally, people spread the bacteria to others through respiratory droplets or direct contact. Rarely group A strep bacteria can be spread through food that isn't handled properly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Categories of Transmission-Based Precautions, revised September 2020, indicated but was not limited to the following: -Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. -Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. -Based on CDC definitions, three types of Transmission-Based Precautions (airborne, droplet, and contact) have been established. Contact Precautions: -In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. -In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. -Wear a disposable gown upon entering the Contact Precaution room or cubicle. Droplet Precautions: -In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). -In addition to Standard Precautions, put on a mask when entering the room or cubicle. -Signs - the facility will implement a system to alert staff and visitors to the type of precaution the resident requires. a. On 4/25/25 at 8:33 A.M., the surveyor observed Nurse #2 inside a GAS positive resident's room administering medications. Nurse #2 was not wearing PPE. A Quarantine Droplet/Contact isolation sign was posted outside the door that indicated the following: -STOP: Quarantine Droplet/Contact precautions in addition to standard precautions - only essential personnel should enter this room -EVERYONE MUST: including visitors, doctors, staff = wash hands, wear gown, mask, eye protection, gloves, keep door closed when performing an aerosol generating procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/25 at 8:33 A.M., Nurse #2 said the resident was Strep positive but thought she only had to wear PPE with direct care. Nurse #2 reviewed the sign posted with the surveyor and said the sign indicated she should have had full PPE on including a gown, eye protection, gloves, and a mask on but didn't. She said the sign, being located on the door and not outside the door, makes it hard to see prior to entering the room and she must have missed it. b. During an observation with interview on 4/25/25 at 8:39 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 entering a GAS positive resident's room delivering a breakfast tray and offering to assist him/her in sitting up. CNA #1 was not wearing PPE. An Enhanced Barrier Precaution (EBP- expands the use of gowns and gloves during high-contact resident care activities) sign and Quarantine Droplet/Contact isolation sign was posted outside the door. CNA #1 said she was told if they are just going in and not touching a resident, they do not need PPE on and pointed to the orange EBP sign. When asked what resident the yellow Quarantine sign pertained to, she said she didn't know, but upon reading it, she said she should not have been in the room at all without PPE and had made a mistake. c. During an observation with interview on 4/25/25 at 9:11 A.M., the surveyor observed the Activities Director (AD) in the middle of a GAS positive resident's room addressing all four residents occupying the room wearing only a surgical mask. The AD was not wearing a gown, eye protection, or gloves. Upon exiting the room, the AD said she was told they could go into any room without PPE as long as they weren't touching the residents or providing direct care. Upon review of the Quarantine signage posted, she said the sign indicated she should have had full PPE on, and she did not. During an interview on 4/28/25 at 3:12 P.M., the surveyor reviewed the positive GAS residents with the DON who said they were immediately placed on contact/droplet precautions and started antibiotic treatment on 4/24/25. The DON said staff have to wear a gown, gloves, eye protection, and a mask upon entering a contact/droplet precaution room and it did not matter if only one resident was positive in the room, they were still required to wear full PPE prior to entering the room. 2. Review of the facility's policy titled Surveillance for Infections, revised September 2020, indicated but was not limited to the following: -The Infection Preventionist (IP) will work together with the Contracted Laboratory to conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. This information is reviewed with the ICP weekly and data brought to the quarterly QAPI and Infection Control Meetings. -The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infection. -The criteria for such infections are based on the current standard definitions of infections. Nursing staff will monitor residents with signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the Charge Nurse as soon as possible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures. Gathering Surveillance Data: -The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. The Infection Control Committee and/or QAPI Committee may be involved in interpretation of the data. -The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: a. Laboratory records; b. Skin care sheets; c. Infection Control rounds or interviews; d. Verbal reports from staff; e. Infection documentation records; f. Temperature logs; g. Pharmacy logs; h. Antibiotic review; and i. Transfer log/summaries Data Collection and Recording: -For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: a. Identifying information (i.e., resident's name, age, room number, unit, and attending physician); b. Diagnosis; c. admission date, date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test); d. Infection site; e. Pathogens; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Invasive procedures or risk factors; g. Pertinent remarks; and h. Treatment measures and precautions 2. Using the current suggested criteria for Healthcare-Associated Infections, determine if the resident has a Healthcare-Associated Infection 3. Daily (as indicated): Record detailed information about the resident and infection on an individual infection report form 4. Monthly: Collect information from individual resident infection reports and enter line listing of infections by resident for the entire month and summarize monthly data for each nursing unit by site and by pathogen. During an interview on 4/28/25 at 3:38 P.M., the DON said she used McGeer (evidenced based surveillance) criteria to define infections. Review of the revised 2024 McGeer criteria indicated but was not limited to the following: Syndrome Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 2 1. At least one of the following signs or symptoms Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, and >1 of the following: -Acute costovertebral angle pain or tenderness -Suprapubic pain -Gross hematuria -New or marked increase in incontinence -New or marked increase in urgency -New or marked increase in frequency If no fever or leukocytosis, then >= 2 of the following: -Suprapubic pain -Gross hematuria (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New or marked increase in incontinence -New or marked increase in urgency -New or marked increase in frequency 2. At least one of the following microbiologic criteria -50,000 cfu/ml of no more than 2 species of organisms in a voided urine sample -20,000 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter Syndrome: Cellulitis, soft tissue, or wound infection Must fulfill at least 1 criterion: Pus at wound, skin, or soft tissue At least four of the following new or increasing signs or symptoms -Heat -Redness (erythema) at affected site -Swelling at affected site -Tenderness or pain at affected site -Serous drainage at the affected site At least one of the following: -Fever -Leukocytosis -Acute changed mental status -Acute functional decline Syndrome: Fungal Skin Infection Must fulfill 1 and 2 1- Characteristic rash or lesions 2. Physician diagnosis or lab confirmation of fungal pathogens from skin scraping or biopsy (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's monthly surveillance line listings from January 2025 through April 2025 indicated but was not limited to the following: February 2025: Resident #2: Category: UTI/O (other); Date of onset 2/13/25; Symptoms P (pain)/MD (doctor); Final status HAI; Count, Yes The February surveillance line listing did not have enough symptoms documented to indicate any McGeer infection for skin had been met in accordance with the facility pre-defined criteria and, therefore, should not have been counted as an HAI infection within the facility. March 2025: Resident #1: Category UTI; Date of onset 3/20/25; Symptoms MD DX (diagnosis); Final status HAI; Count, Yes The March 2025 surveillance line listing did not have symptoms documented to meet the criteria for a UTI in accordance with the facility's pre-defined McGeer criteria and, therefore, should not have been counted as an HAI infection within the facility. During an interview on 4/29/25 at 2:00 P.M., the surveyor reviewed the February 2025 and March 2025 surveillance line listings with the DON who said her expectation is that they would be complete and accurate and meet the McGeer criteria for the definition of infection, but they were/did not. 3. Review of the facility's policy titled Enhanced Barrier Precautions, effective date 3/20/24, indicated but was not limited to: - Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities. - EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. - EBP are indicated for residents with any of the following: - Wounds even if the resident is not known to be infected or colonized with MDRO. Review of the facility's policy titled Wound Care, revised September 2020, indicated but was not limited to: - Put on exam gloves. Loosen tape and remove dressing. - Pull gloves over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Put on gloves. - Use no-touch technique. Use sterile tongue blades and applicators to remove ointment and creams from their containers. Review of Lippincott Nursing Procedures, Eight Edition, indicated but was not limited to the following: Hand Hygiene is a general term used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) to refer to hand washing, antiseptic hand washing, and antiseptic hand rubbing. Hand hygiene is the single most important procedure in preventing infection. Using an alcohol-based hand sanitizer is appropriate for decontaminating the hands before putting on gloves, after removing gloves, and wound dressings (if hands aren't visibly soiled). Always perform hand hygiene before putting on gloves to avoid contaminating the gloves with microorganisms from your hands. Resident #10 was admitted to the facility in February 2022 with diagnoses including dementia and bullous pemphigoid (chronic, autoimmune skin condition that causes large fluid-filled blisters). On 4/25/25 at 12:01 P.M., the surveyor observed an EBP sign, undated, outside Resident #10's room, which indicated but was not limited to the following: STOP, ENHANCED BARRIER PRECAUTIONS, EVERYONE MUST: - Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: - Wear gloves and a gown for the following High-Contact Resident Care Activities. - Dressing; Bathing/Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - Wound Care: any skin opening requiring a dressing Review of Resident #10's current Physician's Orders indicated but were not limited to: - Betamethasone Dipropionate External Ointment 0.05 % (an ointment reduces the swelling, itching, and redness that can occur) Apply to wounds/lesions topically every day and evening shift for wound care, 4/27/2025 - Bilateral upper extremity wound care twice daily and as needed for integrity: 1. Wash off drainage and pat dry 2. Apply beclomethasone ointment to all wounds and lesions 3. Cover wounds and lesions with xeroform gauze 4. Cover with gauze and abdominal pads 5. Wrap from hand to shoulder with gauze wrap (DO NOT remove foam dressings from LUE (left upper extremity) unless impaired or scheduled dressing day) every day and evening shift for wound care and as needed, dated 4/28/2025 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Bilateral lower extremity wound care twice daily and as needed for integrity: 1. Wash off drainage and pat dry 2. Apply beclomethasone ointment to all wounds and lesions 3. Cover wounds and lesions with xeroform gauze 4. Cover with gauze and abdominal pads 5. Wrap from foot to knee with gauze wrap every day and evening shift for wound care and as needed, dated 4/28/2025 During the wound dressing observation on 4/28/25 at 12:19 P.M., the surveyor observed the following: - Nurse #2 applied the prescribed ointment to Resident #10's right lower extremity using her gloved hand and completed the dressing to the right lower extremity as ordered, without being observed to change her gloves or perform hand hygiene. Nurse #2 then removed the dressing on Resident #10's left lower extremity, cleaned the wound, patted the wound dry, applied the prescribed ointment to her gloved hand then applied that ointment to Resident #10's wound, at no time during this process was she observed to change her gloves or perform hand hygiene. - Nurse #1, assisted Nurse #2 by lifting Resident #10's right lower extremity up off the bed, with his bare hand, without being observed to put any gloves on, while Nurse #2 wrapped the left lower extremity wound with gauze. - Nurse #2, without changing her gloves, after completing the lower extremity wound care, was observed to remove the dressing on Resident #10's left upper extremity (LUE). Nurse #2 doffed (removed) her gloves and donned (put on) new gloves without performing hand hygiene after the dressing was removed. Nurse #2 then cleansed the wound, patted the wound dry, applied the prescribed ointment to her gloved hand and applied it to the wound. She then doffed her gloves and donned new gloves but was not observed to perform hand hygiene following the removal of her gloves. Nurse #2 completed the dressing as ordered to the LUE but was not observed to change her gloves or perform hand hygiene prior to removing the dressing on Resident #10's right upper extremity (RUE). With the same dirty glove, Nurse #2 then cleansed the RUE wound, patted it dry, applied the prescribed ointment to her gloved hands and then applied it to the wound. Following this, Nurse #2, doffed her gloves and donned new gloves, but was not observed to perform hand hygiene. She then completed the RUE dressing as ordered. - Nurse #1 doffed his gloves and he and Nurse #2 boosted and repositioned Resident #10 in bed. Nurse #1 exited Resident #10's room and was observed to doff his gown and gloves but not to perform hand hygiene after removing his PPE. During an interview on 4/28/25 at 1:58 P.M., Nurse #2 said she should not have used her soiled gloves to perform clean dressing change technique. Nurse #2 said once she removed the soiled dressing she should have changed her gloves and performed hand hygiene prior to donning clean gloves. Nurse #2 said she should have followed infection control practices. During an interview on 4/28/25 at 2:10 P.M., Nurse #1 said Resident #10 was on EBP for his wounds. Nurse #1 said he should have been wearing gloves during high contact care with Resident #10 and should not have touched the resident with ungloved hands. Nurse #1 said infection control practices should have been followed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/28/25 at 2:22 P.M., the DON said her expectation was for all nurses to follow the facility's infection control policies and procedures. The DON said hand hygiene should have been performed when Nurse #1 changed her gloves. The DON said during high contact care Nurse #1 should have been wearing gloves.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview, record review, and document review, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols in accordance with the facility's antibiotic stewardship program for two Residents (#1 and #2), out of a total sample of 13 residents. Findings include: Review of the facility's policy titled Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, revised 9/17/20, indicated but was not limited to the following: -Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. -The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -At the conclusion of the review, the provider will be notified of the review findings. -All resident antibiotic regimens will be documented on the facility-approved antibiotic stewardship surveillance tracking form. The information gathered will include a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic (see approved surveillance list); e. Start date of antibiotics; f. Site of infection; g. Date of culture; h. Stop date; i. Total days of therapy; j. Outcome; and k. Adverse events (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/25 at 7:27 A.M., the Director of Nursing (DON) said she was also the Infection Preventionist (IP). During an interview on 4/28/25 at 3:38 P.M., the DON said she used McGeer (evidenced based surveillance) criteria to define infections. Review of the revised 2024 McGeer criteria indicated but was not limited to the following: Syndrome: Urinary Tract Infection (UTI) without indwelling catheter Criteria: Must fulfill both 1 and 2 1. At least one of the following signs or symptoms Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate Fever or leukocytosis, and >1 of the following: -Acute costovertebral angle pain or tenderness -Suprapubic pain -Gross hematuria -New or marked increase in incontinence -New or marked increase in urgency -New or marked increase in frequency If no fever or leukocytosis, then >= 2 of the following: -Suprapubic pain -Gross hematuria -New or marked increase in incontinence -New or marked increase in urgency -New or marked increase in frequency 2. At least one of the following microbiologic criteria -50,000 cfu/ml of no more than 2 species of organisms in a voided urine sample -20,000 cfu/ml of any organism(s) in a specimen collected by an in-and-out catheter (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Syndrome: Cellulitis, soft tissue, or wound infection Must fulfill at least 1 criterion: Pus at wound, skin, or soft tissue At least four of the following new or increasing sign or symptom -Heat -Redness (erythema) at affected site -Swelling at affected site -Tenderness or pain at affected site -Serous drainage at the affected site At least one of the following: -Fever -Leukocytosis -Acute changed mental status -Acute functional decline Syndrome: Fungal Skin Infection Must fulfill 1 and 2 1- Characteristic rash or lesions 2. Physician diagnosis or lab confirmation of fungal pathogens from skin scraping or biopsy Review of the facility's January 2025 through April 2025 antibiotic surveillance tracking form from January 2025 through April 2025 indicated but was not limited to the following: February 2025: Resident #2: Category: UTI/O (other); Date of onset 2/13/25; Symptoms P (pain)/MD (doctor); Final status HAI; Count, Yes The February antibiotic surveillance tracking form did not have enough symptoms documented to indicate any McGeer infection for skin had been met in accordance with the facility's pre-defined criteria, however an antibiotic was prescribed for 10 days. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's medical record failed to indicate a clinical rationale by the prescribing physician for the initiation of an antibiotic even though the symptoms did not meet pre-defined criteria. During an interview on 4/29/25 at 2:00 P.M., the surveyor reviewed the medical record, tracking form, and McGeer criteria with the IP who said the Resident's symptoms did not meet the criteria per their antibiotic stewardship program for the initiation of an antibiotic and there was no documented clinical rationale by the provider to indicate otherwise. March 2025: Resident #1: Category UTI; Date of onset 3/20/25; Symptoms MD DX (diagnosis); Final status HAI; Count, Yes The March 2025 antibiotic surveillance tracking form indicated a positive urine culture but did not have any symptoms documented to meet the criteria for a UTI in accordance with the facility pre-defined McGeer criteria, however an antibiotic was prescribed for 10 days. Review of Resident #1's medical record failed to indicate a clinical rationale by the prescribing physician for the initiation of an antibiotic even though the symptoms did not meet McGeer criteria. During an interview on 4/29/25 at 2:12 P.M., the surveyor reviewed the medical record, tracking form, and McGeer criteria with the IP who said there were no symptoms documented for the Resident, and it did not meet the criteria for the initiation of an antibiotic. She said there was no documented clinical rationale by the provider to indicate otherwise. During an interview on 4/29/25 at 2:31 P.M., the IP said the facility used the McGeer criteria as an infection assessment tool and that they had protocols to review signs and symptoms and lab reports to determine if an antibiotic is indicated or adjustments need to be made, and providers should be following the antibiotic stewardship program. The IP said she is always made aware of all clinical infections that are treated with antibiotics and all antibiotic regimens should be documented on the facility approved antibiotic surveillance tracking form. She said there was no clinical rationale for Residents #1 and #2 for antibiotic use.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to ensure two Residents (#34 and #27), out of a total sample of five residents reviewed for immunizations, was screened for eligibility to receive the recommended pneumococcal vaccinations, residents/residents' representatives were educated on the benefits and potential side effects of the vaccine, and was offered and administered (if applicable) the vaccine in a timely manner. Findings include: Review of the facility's policy titled Pneumococcal Vaccine, dated as revised 9/17/20, indicated but was not limited to the following: - all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections - prior to admission residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the series within 30 days of admission to the facility unless medically contraindicated or the resident had already been vaccinated - assessments of pneumococcal vaccination status will be conducted within 5 working days of the resident's admission if not conducted prior to admission - before receiving a pneumococcal vaccine the resident or their legal representative shall receive information and education regarding the benefits and potential side effects of the vaccine; provisions of such education will be documented in the medical record - administration of pneumococcal vaccines or re-vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. Review of the CDC guidance titled Pneumococcal Vaccine Recommendations, dated: 10/26/24, indicated but was not limited to the following: Adults 50 years or older: Routine vaccination Administer PCV15, PCV20, or PCV21 for all adults 50 years or older, who have never received any pneumococcal conjugate vaccine, whose previous vaccination history is unknown PCV15: Additional vaccination needed: If PCV15 is used, administer a dose of PPSV23 a. one year later, if needed b. their pneumococcal vaccinations are complete. The minimum interval is 8 weeks and can be considered in adults with: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An immunocompromising condition, a cochlear implant, cerebrospinal fluid leak, PCV20 or PCV21: Additional vaccination not recommended If PCV20 or PCV21 is used, a dose of PPSV23 isn't indicated. Regardless of which vaccine is used (PCV20 or PCV21), their pneumococcal vaccinations are complete. Recommendation for shared clinical decision-making Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23. During an interview on 4/25/25 at 12:42 P.M., the Director of Nurses (DON) said the vaccination consents are in the paper record and the actual vaccination documentation could be found in the electronic medical record, as the facility had hybrid medical records. Resident #34 was admitted to the facility in February 2025 and was [AGE] years old. Review of the full medical record failed to indicate any pneumococcal vaccination history had been obtained or that the Resident's eligibility for the pneumococcal vaccine had been determined. Further review failed to indicate any education was provided to the Resident or their legally responsible party or that a consent or declination form was obtained. Resident #27 was admitted to the facility in January 2025 and was [AGE] years old. Review of the full medical record failed to indicate any pneumococcal vaccination history had been obtained or that the Resident's eligibility for the pneumococcal vaccine had been determined. Further review failed to indicate any education was provided to the Resident or their legally responsible party or that a consent or declination form was obtained. During an interview on 4/29/25 at 9:08 A.M., Nurse #1 reviewed the medical records of Residents #34 and #27 and said there was no documentation available to determine the Resident's pneumococcal vaccination status, their eligibility, any education had been provided, or that the pneumococcal vaccine had been addressed with the Resident or their responsible parties at all. During an interview on 4/29/25 at 9:14 A.M., the DON said the facility does not obtain MIIS (Massachusetts immunization information system) documentation on residents and she does not have access to the site. She said there is no evidence or documentation available in the medical records for either Resident #34 or #27 that would indicate they have eligibility for the pneumococcal vaccine, or that the vaccine has been addressed at all with the Resident's or their legally responsible parties and there should be.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on document review and interview, the facility failed to provide education and offer COVID-19 vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations for four Staff members out of a total sample of five staff reviewed for immunizations. Findings include: Review of the facility's policy titled COVID-19 Personnel vaccination requirement, dated as revised 4/1/25, indicated but was not limited to the following: - it is the policy of [Facility name] that all staff members are up to date with vaccine doses of COVID-19 as recommended by the CDC. Review of the CDC guidance titled Stay Up to Date with COVID-19 Vaccines, revised 1/7/25, indicated but was not limited to the following: - Getting the 2024-2025 COVID-19 vaccine is important because: protection from the COVID-19 vaccine decreases with time; immunity after COVID-19 infection decreases with time; COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. - Everyone ages 6 months and older should get the 2024-2025 COVID-19 vaccine. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. People ages 12-64 years; You are up to date when you have received: - 1 dose of the 2024-2025 Moderna COVID-19 vaccine OR - 1 dose of the 2024-2025 Pfizer-BioNTech COVID-19 vaccine OR - 1 dose of the 2024-2025 Novavax vaccine unless you are receiving a COVID-19 vaccine for the very first time. If you have never received any COVID-19 vaccine and get Novavax, you need 2 doses of 2024-2025 Novavax COVID-19 vaccine to be up to date. Review of the staff medical record for immunization information for Nurse #1, Nurse #3, Certified Nurse Aide (CNA) #3 and CNA #4 failed to indicate the facility assessed the staff's eligibility and offered the COVID-19 vaccine providing them with education and having proof that the vaccination was offered and accepted or declined. During an interview on 4/28/25 at 2:36 P.M., the Director of Nurses reviewed the employee files and said she could not locate any documentation or proof that the four staff members had been provided education on the new 2024-2025 COVID vaccination or offered the vaccination. She said the facility does not have a form for consent or declination for staff and she was not aware that the facility needed proof that the staff were educated to the vaccine and they were offered the vaccination if they chose. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/29/25 at 12:57 P.M., the Administrator said the facility are offered the COVID-19 vaccination upon hire and when a new booster is available. He said at this time there are no documents that the facility uses to prove they have offered the vaccine or vaccine education to the staff, and it is a work in process that has not been implemented at this time.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review, and interview, the facility failed to complete a new assessment of the bed, side rails and mattresses in active use for potential entrapment when the bed mattress was changed from the previously assessed mattress, placing two Residents (#22 and #34), out of a sample of 12 residents, who had limited mobility and utilized bilateral side rails, at risk for possible entrapment. Following an interview with the facility's Maintenance Director, it was determined that 38 of 38 beds in use in the facility were affected. Findings include: Review of the facility's policy titled Proper Use of Siderails, revised 2/1/2018, indicated but was not limited to the following: - Manufacturer instructions for the operation of side rails will be adhered to. - When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment (the amount of space may vary, depending on the type of bed and mattress being used). Review of the Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006, indicated the following: The term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Resident entrapments may result in deaths and serious injuries. There are seven zones of bed entrapment: Zone One (within the rail), Zone Two (under the rail), Zone Three (between rail and mattress), Zone Four (Under the rail, at the ends of the rail), Zone Five (between split bed rails), Zone Six (between the End of the Rail and the Side Edge of the Head or Foot Board) and Zone Seven (Between the Head or Foot Board and the Mattress End). The hospital bed dimensional limit recommendations are as follows: -Zone One: 4.75 inches -Zone Two: 4.75 inches -Zone Three: 4.75 inches -Zone Four: 2.375 inches and 60-degree angle 1. Resident #22 was admitted to the facility in December 2024 with a stage four pressure ulcer (full-thickness skin loss that extends through the fascia with considerable tissue loss due to prolonged pressure exerted over specific areas of the body). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225752	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Serenity Hill Nursing Center	655 Dedham St Wrentham, MA 02093

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Minimum Data Set (MDS) assessment, dated 3/13/25 indicated Resident #22 was cognitively intact as evidenced by a BIMS score of 15 out of 15, had a stage four pressure ulcer and utilized a pressure reducing device in bed. On 4/25/25 at 8:54 A.M., the surveyor observed Resident #22 lying in bed asleep with bilateral side rails up and in use. An air mattress was on the bed and set to 350 pounds (lbs.). On 4/27/25 at 11:20 A.M., the surveyor observed Resident #22 sitting upright in bed with bilateral side rails up and in use. An air mattress was on the bed and set to 350 lbs. On 4/29/25 at 9:15 A.M., the surveyor observed Resident #22 sitting upright in bed with bilateral side rails up and in use. An air mattress was on the bed and set to 350 lbs. Review of the medical record indicated the following Physician's Orders: - May use bilateral siderails for turning and repositioning (12/5/24) 2. Resident #34 Resident #34 was admitted to the facility in February 2025 and had diagnoses including Alzheimer's disease and a history of falls. Review of the MDS assessment, dated 2/12/25 indicated Resident #34 had severe cognitive impairment as evidenced by a BIMS score of 99, indicating he/she was unable to complete the assessment, and had a pressure reducing device in bed. On 4/25/25 at 9:02 A.M., the surveyor observed Resident #34 lying in bed awake with bilateral side rails up and in use. An air mattress was on the bed and set to 400 lbs. On 4/28/25 at 8:12 A.M., the surveyor observed Resident #34 lying in bed asleep with bilateral side rails up and in use. An air mattress was on the bed and set to 400 lbs. Review of the medical record indicated the following Physician's Orders: - May use bilateral siderails for turning and repositioning (2/6/25) During an interview on 4/30/25 at 12:05 P.M., the Maintenance Director said he has not conducted bed entrapment checks of any beds in the facility since the start of his employment in early 2024. He said he was never told by the Administrator that bed entrapment assessments had to be conducted and there is currently no process in place. On 4/30/25, the facility Administrator faxed the survey team a list of residents in the facility that utilize side rails. Review of the document indicated that 38 of 38 residents in the facility utilize side rails. No additional information was provided by the facility to ensure beds were being assessed for risk of entrapment.